DDRS Policy Feedback Comments and Clarification

Policies Issued as Final effective March 16, 2012

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Contents

Provider Reapproval

Under Item #2, should the list of criteria include current accreditation status, where appropriate?

Agreed. This has been added.

Who are the members of the DDRS Sanctioning Committee? What are the qualifications and experience required to be a member of the committee? How are members of the committee appointed and/or removed? What criteria do they use to evaluate providers referred to them for review? Are the DDRS Sanctioning Committee meetings open to the public?

Members of the Committee include representatives from BQIS and BDDS. They are appointed and removed by the Director. These meetings are not open to the public. The sanctioning committee policy will be posted in its finalized version soon.

Who, or what positions, will be on the Sanctioning Committee?

See above.

It indicates that a provider may be referred to the DDRS Sanctioning Committee, under what circumstances would a referral be made? Conversely, when would a provider not be referred to the sanctioning committee? May the provider have representation during the review by the Sanctioning Committee? Are the findings of the Committee appealable? If so, to whom?

This has been changed from "may" to "will be referred".
The provider may have representation during the review.
The findings are appealable under administrative review.

During the probationary period, how does the provider show compliance with the requirements? Who manages this process?

The provider shows compliance by responding to the specific issues in the manner indicated in #4 in the policy. BQIS and Provider Relations manage and monitor this process.

For Item 4.a.ii., in terms of identifying all systemic problems, who or how are these problems identified?

Specific problems will be identified in the letter sent to the provider. BQIS identifies the problems.

As referral to the sanctioning committee is permissive, should Item 4.a.iii. include the phrase "if applicable"?

Disagree.

It indicates that a provider review may go before the DDRS Provider Review Committee, under what circumstances would a provider go before the committee? Conversely, when would a provider not go

before the committee? May the provider have representation during the review? Are the findings of the committee appealable? If so, to whom?

This has been changed to indicate that every decision for approval will go through Provider Relations. The provider does not actually appear before Provider Relations, so no representation is necessary at this stage. The findings are appeal under administrative review.

#5 – states reviews "may" go before the DDRS Provider Review Committee for final decisions. Under what circumstances would this happen? Shouldn't they all go?

See above.

Who are the members of the DDRS Provider Review Committee? What are the qualifications and experience required to be a member of the committee? How are members of the committee appointed and/or removed? What criteria do they use to evaluate providers referred to them for review? Are Provider Review Committee meetings open to the public?

The line should read "Provider Relations" instead of DDRS Provider Review Committee, and this is not open to the public. The DDRS Provider Review Committee consists of DDRS staff who will consider matters related to supervised group living, and these meetings will be open to the public.

On page 1, under 4-a-iii: Compliance is spelled incorrectly

This has been changed.

We recommend under #2 concerning criteria for reapproval purposes that, for clarity, you add another category: Add----Complaints of Staff Discrimination against clients being investigated by the Office of Civil Rights. Your point b is too vague.

At this time, we are not prepared to add this criterion.

I would like to suggest that the definition for CERT be added to those listed in the Provider Reapproval Policy.

This has been added.

How will this affect providers who have completed the CERT process in 2011? Should we expect another CERT survey in 2012?

The reapproval process will follow behind the CERT process. In this instance, the 2011 CERT will be used as a data point for the provider's reapproval.

Detailed Policy Statement #2—if you haven't yet had a CERT survey, will they do one before you can be reapproved? Shouldn't Indiana State Department of Health Surveys of SGL sites be included here as well? If so, something will also need to be added to the reference section.

See above. This policy concerns Medicaid Waiver providers.

On Policy # 460 0000 042 "Provider Reapproval" under 2. a. it is my understanding that most agencies won't have to have a CERT survey done if they have a CARF survey done.

This is true; however, this is only applicable to Adult Day Services at this time.

#4-a.-i.—what are the acceptable timeframes for incidents, etc to be open?

Please see the BQIS policy on Incident Reporting and Management. This can be found online at http://www.in.gov/fssa/ddrs/3340.htm.

Administrative Review #1 – Is a DDRS order the same as a Sanctioning Committee order? This should be consistent throughout the policy.

This has been clarified in the policy.

Can you give examples of "Other information DDRS deems necessary?" This seems very subjective and open to broad interpretation.

As we refine this new process, we believe it is necessary to allow for additional information to be used in the future.

Also, under 2.c. will agencies be penalized for strictly following the incident reporting requirements while the ones who don't follow them will be rewarded for not following the letter of the regulation?

No. When a provider scores above or below the average incidents reported, additional inquiry will be made to determine the circumstances behind the apparent over or under reporting.

Providers Adding Counties and Services

Where is the Application to Provide Counties located? What information is needed to complete the application?

This will be a form posted for adding counties and services on our website.

Who are the members of the DDRS Provider Review Committee? What are the qualifications and experience required to be a member of the committee? How are members of the committee appointed and/or removed? What are the criteria used to evaluate the applications received? Are Provider Review Committee meetings open to the public?

The line now reads "Provider Relations." This is not open to the public.

Definitions: DDRS Provider Review Committee – it references functions previously assigned to the Community Residential Facilities Council. Since this council no longer exists, in future how will we

know what they used to do? Providers, staff, families and clients new to the system will be clueless as to what this means.

This reference has been removed. Please see above.

If an application is denied, what information will be provided as to the reason for the denial? What administrative appeal rights are available in the event that an application is denied?

Provider Relations will identify a reason for the denial. Administrative appeal rights can be found in IC 4-21.5-3-7.

What types of additional information would be requested by BDDS Provider Relations?

Examples include a new provider agreement form and provider data form. Other documents will be requested depending on the specific services indicated on the application.

How is that additional information used? How is it different from the information provided along with the application?

See above.

If the pick list is the primary venue for consumers to learn about available providers and a provider is not currently providing a particular service or serving a particular county and therefore not on the pick list, in what situations would the provider be able to show a specific individual identified in the county or for the service requested?

If a provider knows of someone requesting a particular service or wanting services in a particular county, the provider needs to inform Provider Relations.

In terms of the showing a justification for expanding the provider's business into a new county or service, what criteria are used to evaluate such justifications? Are there examples of what justifications are anticipated to be approved?

A provider needs to be able to show an ability to provide the service, the need for the service in the county, or the ability to provide the service in the requested county.

At the bottom of page 1, point 2 states: "If a specific individual is identified to in the county requested or for the service requested, the provider may ask for an expedited application review." This is unclear; perhaps a typo? Maybe remove the word "to" after identified?

This has been changed.

Providers Adding Counties #4 and Providers Adding Services #3 – Approvals are based on the need, how is the need determined?

County-specific data is available on the DDRS website. Providers may show need based on this data.

Providers adding Counties, #4—how is need for service evaluated? What if there is a provider but a competitor thinks they can do better? Does the provider with the most friends in the state office get approved? Also in this item, how are open CAP's evaluated? In what timeframe do you need to have no open CAP's? And do they look at all your departments or just the one that would be adding the service?

Need can be evaluated based on the statistics on the DDRS website.
If a provider thinks they can do better than a competitor, then they need to provide reasonable justification.
No.
CAPs are evaluated according to BQIS policy, which can be found at http://www.in.gov/fssa/ddrs/3340.htm.

Policy statement--Why is it the state's business if a provider has a strong business interest to support expansion? If the intent is to clean up the pick list (a worthy goal), it would make more sense to require proof of actual preparation to provide—how service would be supported, etc.

We would expect this as a reasonable justification to provide services.

General—We are assuming they are looking at the county where the service is actually provided, even if that is different from where the client lives—that we are OK to be providing day service in St. Joseph County even though some people who live in Elkhart drive here to receive the service.

We are looking at the county where the service is actually provided. Given the limited information in this comment, Provider Relations would be likely to add Elkhart County to the provider's counties served.

Would be helpful to know what the application covers.

This will be posted on the website.

Providers Adding Counties or Services, #2—good to know they would expedite, but how would you identify an individual in the county requesting your service if you are not on the pick list for that service. Makes you wonder where they are intending to go with the pick list / INSYNC process.

Some examples we have seen come from recommendations through word of mouth and instances where clients move to another county and would like services in that county.

Can you explain why such an extensive review is needed to add a county? I understand that DDRS needs to ensure the pick lists are correct and that providers are actually providing services or willing to provide services in a county they are listed under, however it seems that adding a county should be a formality to ensure the accuracy of those things instead of something that is strictly regulated, since each provider is approved to provide services in the State and is funded via the state and not by each county.

The review identifies the services currently needed and where the services are needed.

How will a provider expand into new counties? By this rule, a provider cannot expand into a county unless they have an individual interested in their services, or if the provider has justification. What kind of "justification" is required other than a provider wants to serve more individuals? An individual may not know of a provider if they are not on the pick list yet a provider cannot get on the pick list for a new county unless they have an individual who wants to utilize that provider? This seems more likely to prevent new business and prevent providers from moving into rural areas where there is a need for new providers.

We are not trying to limit the expansion of a provider's business.

While I understand the need to clean up pick lists and alleviate confusion for the consumer/families as they choose providers, I don't understand the need to complete a provider application to provide currently approved services across a county line? In a meeting that I attended a month ago, a DDRS staff member explained to the group that adding a county back into our service area was as easy as making a telephone contact with that person? It seems to me after reading this policy as it is presently written, that would not be the case?

That is the process until this policy is effective; however, there is still an expectation that a provider justifies why they would like to add a county. As for the new process, DDRS will consider all reasonable justifications for adding counties and services.

Transition Activities

Is it correct to assume that this policy applies to changes in service providers for all waiver services? We would recommend adding information to clarify which waiver services are impacted by the policy.

This applies to all waiver services.

Given their role in transition monitoring, should case management be reflected within this section?

No.

Should the exiting provider also have responsibilities in terms of supporting transition activities?

It is our expectation that all providers should work together to facilitate a smooth transition for the individual.

#3 - If a provider has admissions suspended for not following the policy, how long is the suspension and how is the issue resolved? This issue needs clarified.

This is determined by the Sanctions Committee.

On Policy #460 0000 31 "Transition Activities" under 3. it seems like the death penalty is a little harsh.

Unapproved transitions are taken seriously.

The only difference I could find between this policy and that previous version was in 5-B-vii—it used to say "Change in other waiver service provider" and they've removed the word "other" in this version. So, questions remain essentially the same as those submitted on the last version. Wording indicates to me that they mean this cover changes in providers for any service, not just residential.

Yes. This covers changes in providers for any service.

How is BDDS written approval for transition indicated—is there a specific form?

In supported living, the transition plan is signed. In SGL, the transition plan is signed and there is a signed Residential Approval Form that documents BDDS approval.

There are no timeframes for when meetings of these activities are supposed to take place. The Case Managers are specifying timeframes.

This is procedural.

I understand the reasoning behind BDDS being the placement authority. However, I do feel that there needs to be additional information/guidelines as to why BDDS can disapprove placement for an individual that would like to change residential providers. It has always been my belief that consumers have a choice as to their residential provider.

BDDS remains placement authority under Indiana Code and must approve all transitions.

If an individual is solely changing addresses and is being supported by the same provider and the same staff. I feel that BDDS should be able to differentiate and not have all of the staff go through training again. This is not very cost productive.

Staff do not have to be retrained; however, BDDS needs documentation that the staff working with the individuals have been trained on all current plans including ISP, Behavior Support Plans, and Risk Plans.

Mandatory Components of Incident Investigation

From Policy Statement, this does not appear to apply to SGL.

ISDH has its own complaints and investigation department for SGLs.

Based on the policy statement is it appropriate to assume that this policy does not apply to Supervised Group Living?

See above.

Perhaps a clarification of need for investigation under significant injuries of unknown origin. Perhaps as defined by reporting guidelines?

Agreed. Please use the Incident Reporting policy guidelines to determine if the unknown injury is significant.

Also, a clarification for current reporting of incidents of unknown origin…is that also significant injuries?

See above.

I disagree with 1. C. Investigations into injuries of unknown origin –as an all inclusive statement

We recommend the following statement: Investigations into injuries of unknown origin where a nursing assessment indicates suspicious bruising, injury, lacerations, burns

See above.

1-c—All injuries of unknown origin, even minor ones? BDDS reporting policy only requires reporting of injuries that could be caused be abuse / neglect. (I know you may have to investigate to determine if an injury had these causes, but still we need wording to avoid mandated investigation of all injuries—perhaps it could be for injuries that are significant or of suspicious origin.) The Investigation Template says it's for use re: "Significant" Injuries of Unknown Origin.

See above.

Item #1. A. c. – Injuries of Unknown Origin seems very broad, as it could equally apply to a significant injury resulting in the need for medical attention as it does to a small bruise on someone's forearm. It may be helpful to either more narrowly define the term in the definitions section by suggesting that they are injuries or a pattern of injuries that suggest the potential of abuse/neglect and/or require medical intervention. Alternatively, the policy could tie either to the existing Incident Reporting policy or to the Investigation Template, which qualifies such injuries as significant.

See above.

Under Activities initiated by a provider that require mandated components, "Investigations into injuries of unknown origin;" I think it would be more appropriate for this to say: Investigations into significant injuries of unknown origin; - this is the verbiage that is used on the provided form and in the incident reporting policy.

See above.

Also, if somehow, patterns have been explained and addressed previously, perhaps they would not have to be investigated every time?

Not at this time.

1-b—I don't see the timeline format in the Template.

The timeframe for death of an individual is listed in the Mortality Review policy.

The recommended timeframe is within ten (10) days. The expectation is that an investigation will be started within twenty-four (24) hours.

Any timeline requirements?

See above.

Does the Division have expectations regarding timelines for beginning and/or completing investigations after notification of an event/incident?

See above.

Mandated Components Item b. – It does not appear that a timeline of events section was included in the DDRS Template for Providers' Investigations.

See above.

1-d-iii---This gives case managers a lot of leeway, and this gives agencies no recourse. There should be parameters for these requests.

This has been changed.

Item #1.A.d.iii. – What parameters will be provided to case managers to support them in deciding whether to request an investigation? What recourse is available to providers that believe the case manager is requesting unwarranted investigations and/or using this authority in an inappropriate manner?

See above.

Mandated Components
c. A narrative description of the full investigative or review process undertaken? What does it mean by a review process untaken—Can this be defined?

The other items describe what should be include in the narrative, but to make this clearer, this line has been removed.

c—what would this consist of, just a statement describing how you decided who to interview and what to review? It is not in the Investigation Template and seems redundant.

See above.

Mandated Components Item d.iv. – All actual or potential witnesses to the event or alleged event could be an unwieldy number of individuals to identify and/or interview with a limited likelihood of providing meaningful information. Is there a way to narrow this field to a more manageable group that is likely to contribute meaningful information?

No. There shouldn't be a large, unmanageable group, even in a workshop setting. The expectation is that you would ask who saw the incident, and interview them.

Under Mandated components letter d: Identification by name and title of all involved parties including all staff assigned to the victim(s) or alleged victims(s). Is the intent that this is working at the time of the alleged event or for significant injuries of unknown origin is it during the time period leading up to the injury's discovery? Upon reading this initially it sounds as though it is mandated that every staff person assigned to the client whether they were working at the time of the event or not would need to be interviewed. I would appreciate some clarification on this item. As a provider we may have 15 staff assigned to a client, but only two of them are working at a given time. This section also states that all actual or potential witnesses to the event or alleged event. How are you defining "potential witnesses?" Is it up to the provider to define who the potential witnesses are? For example with Unknown injury investigations "potential witness" could be defined as any staff who have worked with the client during the 24 hours prior to the injury being discovered, but would not necessarily be every staff assigned to the client as not all of them had worked with the client in that time period.

1. All staff assigned at the time of the alleged event.

2. This only includes staff that worked with the client in that time period.

It indicates that it requires the following: Signed and dated statements from all involved parties, including all actual and potential witnesses to the event or alleged event. Currently, for our investigations, we complete an Investigation Report that is then signed by the involved parties. In this investigation report, it includes the account of the actual party (typically received by a phone call conversation with the investigator and involved party), regarding the event. Is this sufficient enough, or do we need to have something completely separate that we then attach as an addendum in the Investigation Report?

DDRS requires a signed and dated document, so we would recommend that you do follow up with something in writing.

e. Signed and dated statements from all parties involved. We do not take statements from staff, but rather interview them all to get a much fuller picture. If someone writes out a statement it is often only partial and we still have to interview and ask many more clarifying questions about their statements, so we intentionally do not ask them to write a statement. They often leave out what they choose and many times what they write often has nothing to do with the allegations. We do however include their verbal interview in our investigation summary report. Does this have to be

mandatory? Can it say something like if it is your company policy is to take statements, then include them but not be mandatory?

You can choose to take verbal statements; however, they need to be verified by a signature and date.

e—All involved parties—including all clients who witnessed the event? Many clients cannot give statements. "All actual and potential witnesses of an alleged event is potentially a very large group of people", especially for an incident that happens at a dance, or in a public place like a sporting event. Suggest limiting to witnesses who familiar with the situation and able to provide substantive information.

We agree. The "potential witness" language is in this policy so that you consider all witness who

Mandated Components Item e. – What process should be in place and/or documented for those involved parties that are unable to give a written or verbal statement? How should providers document a party's refusal to offer and/or sign a statement?

DDRS suggests developing a company policy around investigations.

DDRS would not expect a statement from someone who is nonverbal unless someone can interpret. If someone can interpret, the staff can fill out the form and signs the form attesting to what the individual relays.

g. Copies of all records and other documents reviewed that provide evidence support the finding of the investigation or review. Can you further explain what this actually means? On our investigation summary we will reference what documents were reviewed, but do not make copies. If we made copies to keep with the investigation summary report then we could be talking in some cases many, documents. If we copied an ISP, Behavior support plan, daily records for every one investigation that could be a lot of paper when these are documents that are part of a consumers files and can be referenced any time. This could cause significant storage problems if we would do this.

DDRS is only asking for documents that provide evidence, not everything associated with the investigation.

Under Mandated components letter g: Copies of all records and other documents reviewed that provide evidence supporting the findings of the investigation or review. – Can these copies of records be maintained electronically or do we have to maintain hard copies of the documents?

You may store copies electronically; however, they must be accessible when requested.

h—not sure how this is different from items j and k

Item (h.) is different than (j.), so these have been combined into one component.

k. Clear statement of substantiation or non-substantiation. Since we are not persons to make any legal decisions for cases of neglect, abuse, exploitation but are forced to make a decision based on the

information received. We do not use the words substantiate in our findings, but rather use the words "evidence or not evidence to support o the findings" of ….whatever the allegation might be. To me the police or APS, or whoever has the legal authority to make the call whether there something is "substantiated" or "not substantiated". Can this be changed?

DDRS is keeping this language.

l. A definitive description of all corrective actions -- can this say or recommendations?

No. This is a corrective action where the expectation is for the provider to take action.

On the suggested investigation form just prior to the Corrective Action section it states: The following section should be completed by a manager, administrator, or other position with the authority to make management and personnel decisions. This section should not be completed by the investigator. Responsibility for monitoring implementation of corrective action can be delegated. – My question is related to the statement that the corrective action section should not be completed by an investigator. Is the reason for this that if one investigator is conducting the investigation that then a second individual should assess the findings and make recommendations? Our agency has two individuals conduct the investigation and then these investigators meet as part of a committee with at least one additional manager/administrator level staff to discuss the evidence, draw conclusions and make recommendations for Corrective Action. Is there a reason that those who conducted the investigation should not be part of drawing conclusions and making recommendations?

They can be part of the decision making, but the CAP should be approved by management.

m. The signature, name and title of the person completing the investigation. Can this be electronic?

Yes, but it must comply with the standards found in the Individuals Personal Information—Providers Office policy.

Is this completed investigation/template sent somewhere or is it just for the provider's records? To whom? If it needs to be submitted to the state, can the template be added to IR website for submission that way? If sent to CM or Q from another agency, what is to prevent them from editing or twisting what is in the report before submitting follow up to the state?

The case manager should have a copy for review. If necessary, DDRS will request a copy from the provider and will only request a copy from the case manager if the provider refuses to provide a copy.

Is the investigation report intended to be retained by the provider? Is it to be shared or submitted to any other parties?

The report is intended to be retained as a record. Please see above.